# GIC MUNICIPAL ENROLLMENT/CHANGE FORM (FORM-1MUN)

## Health Insurance

Commonwealth of Massachusetts
Group Insurance Commission

REQUIRED

### INSURED INFORMATION

| | | | | |
|---|---|---|---|---|
| **Insured Information** | GIC-ID (usually Soc. Sec. #) – – | Sex ☐ M ☐ F | Date of Birth / / | Dept. ID # or Agency/Division # / |
| | Name – Last | First | | MI |
| **Address** | Street | City | State | Zip |
| **Contact Information** | Home or Cell Phone ( ) | Work Phone ( ) | Email | Country *(if not USA)* |
| **Employment Information** | Date of Hire (must be completed): / / | Name of Municipality: | | |

### REQUIRED FOR ALL NEW ENROLLMENTS

| | | | |
|---|---|---|---|
| **For Agency Use Only** | Does the employee participate in a public retirement system? ☐ Yes ☐ No | Check one: ☐ Full-time ☐ Part-time | Number of work hours/week: |

REQUIRED

**Select all that apply:**

☐ New Enrollment
☐ Adding Dependent(s)
☐ Dropping Dependent(s)
☐ Decline GIC health insurance coverage
☐ Annual Enrollment
☐ Address Change
☐ Name Change

**Qualifying Status Change**

☐ Marriage
☐ Birth/Adoption
☐ Divorce/Legal Separation
☐ Change in Dependent Eligibility Status
☐ Gain of Other Coverage

Date of Event: ____ / ____ / _____

☐ Involuntary Loss of Other Coverage
☐ Return from FMLA or Military Leave
☐ Death of spouse/dependent
☐ Spouse's Annual Enrollment
☐ Moved out of health plan's service area

### HEALTH PLAN

Effective Date: / 01 /

**Health Plan**

☐ Fallon Direct (HMO)
☐ Fallon Select (HMO)
☐ Harvard Pilgrim Independence (POS)
☐ Harvard Pilgrim Primary Choice (HMO)
☐ Health New England (HMO)
☐ NHP Prime–Neighborhood Health Plan (HMO)
☐ Tufts Health Plan Navigator (POS)
☐ Tufts Health Plan Spirit (HMO-type)
☐ UniCare State Indemnity/Basic CIC: ☐ Yes ☐ No
☐ UniCare Community Choice (PPO-type)
☐ UniCare/PLUS (PPO-type)

**Coverage Election**

☐ Individual
☐ Family

**Cancel Health Insurance Coverage:** ☐ Yes ☐ No

### SPOUSE/DEPENDENT INFORMATION *(See instructions on back)*

| For Changes Only | LAST NAME | FIRST NAME | MI | SSN (REQUIRED) | DATE OF BIRTH | SEX | RELATIONSHIP |
|---|---|---|---|---|---|---|---|
| ☐ Add ☐ Drop | | | | | / / | ☐ M ☐ F | |
| ☐ Add ☐ Drop | | | | | / / | ☐ M ☐ F | |
| ☐ Add ☐ Drop | | | | | / / | ☐ M ☐ F | |
| ☐ Add ☐ Drop | | | | | / / | ☐ M ☐ F | |
| ☐ Add ☐ Drop | | | | | / / | ☐ M ☐ F | |

### FORMER SPOUSE INFORMATION – If Listed Above

Date of Divorce: / /

| | | | |
|---|---|---|---|
| Are you remarried? ☐ Yes ☐ No | Date of your remarriage: / / | Has your former spouse remarried? ☐ Yes ☐ No | Date of former spouse's remarriage: / / |
| Address: Street | | City | State / Zip |

SIGNATURE REQUIRED

**AUTHORIZATION –** I have read the instructions on the reverse side of this form and authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected. I understand that due to IRS regulations, my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, death of a dependent, and involuntary loss of coverage). I understand that the GIC must receive any required documentation for health insurance changes within 60 days of the event.

Signature of Applicant: _____ Date: _____

Signature of Authorized Official: _____ Date: _____

| For GIC Use Only | Entered | Verified | Political Subdivision |
|---|---|---|---|

*(See over for Form-1MUN instructions)*

# MUNICIPAL ENROLLMENT/CHANGE FORM (FORM-1MUN) INSTRUCTIONS

**For an overview of your GIC benefit options, see your GIC Benefit Decision Guide www.mass.gov/gic/bdgs.**

## Deadlines and Required Documentation

- **Required Documentation:** To add a spouse or dependent to coverage, documentation is required. Refer to dependent information section below for details.
- **New Hire:** Completed paperwork and required documentation must be received by your GIC Coordinator no later than your 10th calendar day of regular, benefit eligible employment.
- **Annual Enrollment:** Completed paperwork and required documentation must be received by your GIC Coordinator by the end of the Annual Enrollment period.
- **Qualifying Status Change for Health Insurance:** Municipal employees and retirees who have a qualified status change during the year can enroll in GIC health insurance or change from individual to family or family to individual coverage with proof of the family status change. Documentation of the event and the completed form must be received at the GIC within 60 days of the qualifying event. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.
- **Return from FMLA or Military Leave:** If you voluntarily canceled GIC health insurance coverage at the beginning of your FMLA or military leave of absence, you can re-enroll in GIC health insurance coverage upon your return from leave. The enrollment form must be received at the GIC within 60 days of the return to work. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.

## Work Hours and Eligibility

Active municipal employees must work at least 18.75 hours in a 37.5-hour workweek or 20 hours in a 40-hour workweek and must contribute to your employer's public sector retirement system. For GIC purposes, OBRA is not such a retirement system. For additional eligibility details, refer to the GIC's Regulations: www.mass.gov/gic/regulations.

## Dependent Information and Required Documentation

In order to enroll your eligible spouse, former spouse and/or dependents in GIC health insurance, you must enter their information in the spouse/dependent box and provide a copy of a marriage certificate, birth certificate, separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. If covering a former spouse, also complete the former spouse information section. Failure to provide required documentation with this enrollment/change form will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must provide proof of other health insurance coverage. The Centers for Medicare and Medicaid, a federal government agency, requires that valid Social Security Numbers be provided for each dependent to be covered under the health plan. Please indicate the exact date of birth for each dependent. To cover a dependent age 19 to 26, you must also provide a completed Dependent Age 19 to 26 Enrollment and Change Form.

## Form and Documentation Submission

Incomplete forms and insufficient required documentation may result in no coverage or a delayed effective date.

**Active Employees:** Return completed form and documentation to your GIC Coordinator.

*(See over for Form-1MUN)*